

ATTACHMENT 6
Sample CMS 1500 claim form
for speech and language pathology services

HEALTH INSURANCE CLAIM FORM										PICA									
<div style="display: flex; justify-content: space-between;"><div>1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/></div><div>1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890</div></div>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)												
CITY Anytown		STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			CITY		STATE										
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX					ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER M-7												
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>												
b. OTHER INSURED'S DATE OF BIRTH MM DD YY MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME												
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME												
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY (LMP) MM DD YY MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY MM DD YY TO MM DD YY MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY MM DD YY TO MM DD YY MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 436 3. _____ 2. 437.0 4. _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
23. PRIOR AUTHORIZATION NUMBER																			
24. A DATE(S) OF SERVICE To B Place of C Type of D PROCEDURES, SERVICES, OR SUPPLIES E DIAGNOSIS F \$ CHARGES G DAYS OR H EPSTD I J K RESERVED FOR From To Service Service (Explain Unusual Circumstances) CODE \$ CHARGES UNITS Family Plan EMG COB LOCAL USE MM DD YY MM DD YY CPT/HCPCS MODIFIER																			
1 12 04 04 07 10 11 92507 1 XX XX 3.0 12345678																			
2 12 07 04 11 92508 1 XX XX 1.0 12345678																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ XXX XX					29. AMOUNT PAID \$ 00.00					30. BALANCE DUE \$ XX XX									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.M. Authored MM/DD/YY										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) I.M. Pathologist 1 W. Williams Anytown, WI 55555 87654321									
SIGNED _____ DATE _____										PIN# _____ GRP# _____									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)